



State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

FROM: Kathleen D. LeBlanc, RN
Medical Certification Program Manager

SUBJECT: Completion of PPS E Psyche and Rehab Unit
Self Attestations and Unit Criteria Worksheets

Dear Administrator:

PLEASE READ FOLLOWING INSTRUCTIONS CAREFULLY and forward instructions to staff responsible for completing forms. All incomplete or incorrect forms will be returned. Failure to complete forms correctly will delay review and approval for attestation.

Our records indicate that your hospital has a PPS-E Psychiatric and/or Rehabilitation Unit. In order for your PPS-E unit(s) to continue to be eligible for exemption from the Medicare Prospective Payment System (PPS) for your upcoming fiscal year, the Chief Executive Officer or Administrator of your hospital must complete, sign and return the attached Attestation Statement and Unit Worksheets for our review and approval for compliance with all requirements for either PPS-E Psyche or Rehab Units. Psyche and Rehab Units may be excluded from PPS if they meet requirements in the 42 CFR Parts 412.23 through 412.30 and 2803 of the Provider Reimbursement Manual. Excluded units are paid under cost reimbursement rules at 42 CFR Part 413. If a hospital's Unit does not, in fact, meet the exclusion criteria, Medicare payments will be made under the PPS.

PPS-E Units are required to be re-verified for compliance with above requirements. This re-verification must be reviewed within 120 days of the FYE date. For your hospital, this FYE is [date]. In order to continue to receive payment under Medicare and Medicaid as a PPS-excluded unit, an authorized representative of this unit must certify that the unit currently meets and will continue to meet all of the PPS-exclusion criteria. In order to receive this re-verification, the authorized representative of your hospital must complete and return all of the attached forms to this agency by [date /30 days from date on letter], which is within 30 days from receipt of this notice.

INSTRUCTIONS FOR COMPLETING FORMS

Self Attestation Statement Form:

- 1) Complete the attached **Attestation Statement** form. **An original signature is to be provided by the CEO or Administrator. Please PRINT the name and title of this signee.** A name stamp will not be accepted for signature.
- 2) Enter the name of the PPS-E Psyche or Rehab Unit on this form along with the **geographical location (physical address)** of the Unit.
- 3) **List the individual room numbers as well as the number of beds in each room.** You may attach an “addendum” page with a list of room numbers and number of beds in each room if unable to enter all rooms/beds directly on the Attestation Form.
- 4) Enter the **exact square footage of the PPS-E unit.** You may not add square footage to a unit without a prior approval nor may you change rooms or number of beds in a room without prior approval from State Agency. [NOTE: The Psyche Seclusion Room does not have a licensed bed; however this room is included in the square footage of the Unit.]

Psyche (CMS 437 form) and Rehab (CMS 437A form) Unit Criteria Worksheets:

- 1) Complete the “Unit Criteria Work sheet booklet appropriate for your Unit. Enter an “X” or checkmark in “Yes” column for each requirement in the booklet(s) applicable for this Unit.
**** Along with a checkmark of compliance at each requirement, you must also enter either a policy number or a brief statement in each “Explanatory Statement” section – this applies to both the CMS 437 and/or the CMS 437A forms. This information in the “Explanatory Statement” is for State Agency use to verify your compliance at each requirement.**
- 2) Enter the “**Related Medicare Provider Number**” in space provided. This number will be a 19T___ number for a PPS-E Rehab Unit, a 19S___ number for a PPS-E Psyche Unit, or a 19M___ number should you hospital be a Critical Access Hospital (CAH).
- 3) In the space identified on the first page for the “**Survey Date,**” you are to **enter the date on which you are completing the forms.**
- 4) An original, handwritten signature, **(not a stamped signature)** is required by the person who is completes the forms. This signature is to be entered in the “**Verify By**” section of the form and must include the job title and/or discipline of individual completing form. Please type or print the name and title of this individual next to their signature.

***SPECIAL ENTRIES for both CMS 437 and CMS 437A forms:**

- 5) Enter the name and qualification of the Medical Director and the Nursing Director/Manager of the PPS-E Psyche and/or Rehab Units. Please include their length of employment at their respective title/position, as well as length of employment with the hospital at any other job title.

****For the Rehab Medical Director of the PPS-E Rehab Unit only, you must provide documentation that verifies this Director has fulfilled requirement M64. M64 requires the Rehab Medical Director to perform a minimum of 20 hours/week of his services to the Rehab Unit. For verification of M64, please submit completed and signed time logs or time records for the prior 12 month period for which he/she provided services. The logs/records should be clearly understood and document exactly which services were provided for the time reflected in each log. Each log that is submitted must note a signature by the Rehab Director as well as the date on which each record was signed. A dated signature is also to be noted for the staff responsible for reviewing the Medical Director’s time logs.**

6) **FORM CMS 437- Medical Director:** Specifically for the Medical Director of the Psyche Unit, you will note on page 4 at #2, you are to also submit a certificate verifying his/her board eligibility or board certified status in psychiatry as well as hire date as the Psyche Medical Director of the PPS-E Psyche Unit.

7) **FORM CMS 437 – Social Services:** Enter the name and qualification of the Social Service Director of the PPS-E Psyche Unit at #5 on page 6 of booklet. You are to include the length of employment time for this LCSW/Social Service Director as well as his/her LCSW license number and expiration date of license.

This completed paperwork is due in this office no later than [Date 30 days from date on letter].
Please mail completed and signed forms to:

*Department of Health and Hospitals, Health Standards Section
P.O. Box 3767
Baton Rouge, LA 70821-3767
Attn: Hospital Program Manager*

Should your hospital wish to discontinue as a PPS-excluded unit, you must immediately notify both DHH/HSS and CMS Regional Office in Dallas in writing of such action. **The mailing address for sending CMS such notification is:**

*Centers for Medicare and Medicaid Services
Dallas Regional Office
1301 Young Street
Room 833
Dallas, TX 75202
Attn: Rachel McCarty (for PPS-E Rehab Units)
or
Sergio Mora (for PPS-E Psyche Units)*

Please note that all PPS-E units are under a continuing obligation to notify the State Agency if the hospital or unit fails to meet one of the applicable requirements in the period between attestation and start of fiscal year. CMS will continue to verify separately, through the appropriate FI, all compliance with certain criteria (e.g., 75% requirement for rehabilitation units). Please be advised that CMS may validate compliance of any requirement without prior notice.

Please contact me at (225)342-0251 or (225)342-6410 should you have questions related to these instructions for completing of CMS 437 and/or CMS 437A forms.

Enclosures